What's Inside

This benefits comparison chart provides you with an overview of your Choices benefit medical and dental plans. It's been designed to help you choose the plans that are right for you and your family — either during annual enrollment or as a new hire — and also for future reference.

Take some time to also review the Enrollment Highlights Guide and Personalized Enrollment Worksheet you received with this comparison chart for descriptions of your benefit plan options, information about premium rates and the Choices monthly benefit allowance.

Once you've chosen your plans for 2011, you should save this comparison chart so you can refer to it throughout the year.

Remember, information about your Choices benefit plans is also available online 24 hours a day, seven days a week using **mylacountybenefits.com**.

This comparison chart provides a general overview of the Choices benefit medical and dental plans. It is provided for your convenience and is not intended to be detailed or comprehensive. Additional details about your benefits are available in other official plan documents, including official summary plan descriptions. To request a copy of an official plan document, contact the plan's customer service department directly.

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choices

2011
Medical and Dental Plans Comparison Chart

Dental Plans Comparison Chart

	SAFEGUARD	DELTACARE	DELTA DENTAL PLAN			ALADS/BLUE CROSS PREMIER PLANS*	
			PREFERRED PROVIDER OPTION (PPO)	IN-NETWORK	OUT-OF-NETWORK**	IN-NETWORK	OUT-OF-NETWORK**
Type of Plan	An HMO-style dental plan	An HMO-style dental plan	A dental plan that offers two provider networks and out-of-network benefits			An indemnity plan with PPO incentive, offering in- and out-of-network benefits	
Annual Deductible	None	None	None	$50/person; $150/family	$50/person; $150/family	$50/person; $150/family	
Annual Maximum Benefit	None	None	$1,500/person (all care must be from DPO network)	$1,200/person	$1,200/person	$1,500/person	
PREVENTIVE CARE							
Cleaning	100% (two every 12 months)	100% (two every 12 months)	100% (two/calendar year)	80% (no deductible for first two/calendar year)	80% of R&C (no deductible for first two/calendar year)	100%; no deductible (two in 12 months)	100% of R&C; no deductible (two in 12 months)
Exam	100%	100%	100% (two/calendar year)	80% (two/calendar year)	80% of R&C (two/calendar year)	100%; no deductible	100% of R&C; no deductible
Full Mouth X-Rays	100% (one every 24 months)	100% (one every 24 months)	100% (one every five years)	80% (one every five year)	80% of R&C (one every five year)	100%; no deductible (one every 36 months)	100% of R&C; no deductible (one every 36 months)
BASIC SERVICES							
Emergency Treatment	$5 copay	$5 copay	100%	80%	80% of R&C	Covered as regular treatment	Covered as regular treatment
Extractions	100%	100%	85%	80%	80% of R&C	90%	85% of R&C
Fillings	100%	100%	85%	80%	80% of R&C	90%	85% of R&C
General Anesthesia	$30 copay for medically necessary extractions only	$30 copay for medically necessary extractions only	85% for oral surgery only	80% for oral surgery only	80% of R&C for oral surgery only	90%	85% of R&C
Gingivectomy	$55 copay/quadrant	$55 copay/quadrant	85%	80%	80% of R&C	60%	50% of R&C
Root Canals	$45 copay/canal	$45 copay/canal	85%	80%	80% of R&C	90%	85% of R&C
MAJOR SERVICES							
Bridges	$60 copay/unit	$60 copay/unit	50% (once every five years)	50% (once every five years)	50% of R&C (once every five years)	60% (once every five years)	50% of R&C (once every five years)
Crowns	$60 copay/crown	$60 copay/crown	85% (once every five years)	50% (once every five years)	50% of R&C (once every five years)	60% (once every five years)	50% of R&C (once every five years)
Dentures	$70 copay/denture	$70 copay/denture	50% (once every five years)	50% (once every five years)	50% of R&C (once every five years)	60% (once every five years)	50% of R&C (once every five years)
Orthodontia* **	$1,000 copay + $150 start-up fees	$1,150 copay + $350 start-up fees	Not covered	Not covered	Not covered	50% of R&C up to $1,500 lifetime max.	
TMJ	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered

** The ALADS Blue Cross CaliforniaCare and Prudent Buyer Premier Plans provide the dental coverage listed on this chart.*
*** Out-of-network benefits are based on "reasonable and customary" (R&C) amount. You pay your share of R&C if any, plus any amount the provider charges above R&C.*
**** Fire Fighters Local 1014 Medical Plan provides a $2,000 lifetime orthodontia benefit as well as a $1,000 "excess dental" benefit for those participants who exceed their Delta Dental maximum in any year. The plan is only available to members of Local 1014.*

Contact Information

Contact	Phone Number	Fax Number	Web Site
BENEFIT SYSTEM			
Benefit Enrollment	888-822-0487	310-788-8775	www.mylacountybenefits.com
COUNTY DEPARTMENT OF HUMAN RESOURCES			
Benefits Hotline	213-388-9982	N/A	http://dhr.lacounty.info/
MEDICAL			
CIGNA	800-842-6635	N/A	www.cigna.com
Kaiser Permanente	800-464-4000	N/A	www.kp.org/countyofla
ALADS/Anthem Blue Cross (HMO)	800-842-6635	N/A	www.anthem.com/ca/alads
ALADS/Anthem Blue Cross (PPO)	800-842-6635	N/A	www.anthem.com/ca/alads
CAPE/Blue Shield	800-487-3092	N/A	www.blueshieldca.com
Fire Fighters Local 1014	800-660-1014	N/A	www.local1014medical.org
DENTAL			
SafeGuard	800-880-1800	N/A	www.safeguard.net
DeltaCare	800-422-4234	N/A	www.deltadentalins.com
Delta Dental	888-335-8227	N/A	www.deltadentalins.com
ALADS/Blue Cross (dental)	800-842-6635	N/A	www.anthem.com/ca/alads
FLEXIBLE SPENDING ACCOUNTS			
Administrator (Ceridian)	866-300-2303	888-367-3305	www.mylacountybenefits.com
LIFE AND AD&D			
CIGNA Life	800-842-6635	N/A	www.cigna.com

Medical Plans Comparison Chart — County-Sponsored Plans

	KAISER	CIGNA NETWORK HMO	CIGNA NETWORK POS	
			IN-NETWORK	OUT-OF-NETWORK
Annual Deductible	None	None	None	$500/person $1,000/family
Annual Out-of-Pocket Maximum	$1,500/person $3,000/family	1 party-$1,000 2 party-$2,000 Family-$3,000	1 party-$1,000 2 party-$2,000 Family-$3,000	None
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited
PREVENTIVE CARE				**PREVENTIVE CARE**
Immunizations	No charge for most common immunizations	No charge	No charge	60% of R&C after deductible
Periodic Health Evaluations	$10 copay/visit	$10 copay/visit	$10 copay/visit	60% of R&C after deductible
Vision Care	$10 copay for eye exam at Kaiser facility (glasses not covered)	$10 copay for eye exam at contracted facility (one non-medical refraction/12 months) $10 copay for glasses (1 pair/12 months)	Not covered	Not covered
MEDICALLY NECESSARY CARE				**MEDICALLY NECESSARY CARE**
Ambulance	100% if medically necessary	100% when ordered/approved by CIGNA	100% when ordered/approved by CIGNA	Paid as in-network if true emergency, otherwise 60% of R&C after deductible
Doctor Office Visit	$10 copay/visit; no charge pediatric visit to age 5 except routine physical exam	$10 copay/visit	$10 copay/visit	60% of R&C after deductible
Emergency Room	$50 copay; waived if admitted	$50 copay (waived if admitted)	$50 copay/visit (waived if admitted)	60% of R&C after deductible (precertification required for non-emergency hospitalization or $500 penalty and 50% reduction in benefits)
Hospital Care	100%	100%	$50 copay/day; $200 copay annual max	60% of R&C after deductible and after $1,000 fee/admission (precertification required for non-emergency hospitalization or $500 penalty and 50% reduction in benefits)
Maternity	$10 copay for visit to office to confirm pregnancy; no charge thereafter	$10 copay for visit to office to confirm pregnancy, no charge thereafter	Outpatient: $10 copay for visit to confirm pregnancy, no charge thereafter	60% of R&C after deductible
Surgery	Inpatient: No charge Outpatient: $10 copay/visit	Inpatient: 100% Outpatient: $50 copay	Inpatient: 100% after $50 copay ($200 out-of-pocket max/year) Outpatient: $50 copay	60% of R&C after deductible (precertification required for non-emergency hospitalization or $500 penalty and 50% reduction in benefits)
X-Ray & Lab Tests	100% for services at Kaiser facility	100% at a contracted provider	100%	60% of R&C after deductible
Prescription Drugs	$5 copay for up to a 100-day supply of each medication prescribed by Kaiser physician or by any dentist and filled at Kaiser pharmacy. Sexual dysfunction drugs: 50% (limitations apply); $20 copay for brand name	Network pharmacy (30-day supply): generic $5 copay; brand $20 copay Mail order (90-day supply): generic $10 copay; brand $40 copay	Network pharmacy (30-day supply): generic $5 copay; brand $20 copay Mail order (90-day supply): generic $10 copay; brand $40 copay	60% of R&C after deductible; mail order not covered
MENTAL HEALTH CARE				**MENTAL HEALTH CARE**
Mental Health Outpatient	$10 copay/visit	$10 copay/visit	$10 copay/visit	60% of R&C after deductible
Mental Health Inpatient	No charge	100%	$50 copay/day (up to $200/calendar year)	$1,000 deductible per admission plus 60% of R&C after deductible
OTHER PLAN BENEFITS				**OTHER PLAN BENEFITS**
Chiropractic Care	Not covered	Not covered	Not covered	60% of R&C after deductible if medically necessary (up to 25 visits/calendar year)
Home Health Care	100% if within Kaiser service area (up to 2 hrs/visit; 3 visits/day; 100 visits/calendar year)	100% (approved medical provider only)	100% (up to 100 visits/calendar year)	60% of R&C after deductible (up to 60 days/calendar year, reduced by in-network visits)
Hospice Care	100%	100%	100% (with in/out of network combined $10,000 max)	100% of R&C after deductible (with in-/out-of-network combined $10,000 max)
Physical Therapy	$10 copay/visit	$10 copay/visit	$10 copay/visit	60% of R&C after deductible (up to 60 days/condition)
Skilled Nursing Facility	100% (up to 100 days/benefit period)	100% when authorized by PCP (up to 100 days/calendar year)	$50 copay/day, $200 out-of-pocket max/year (up to 100 days/calendar year)	60% of R&C after deductible for semiprivate room rate, plus $1,000 fee/admission (up to 60 days/calendar year)

Important Note: The County believes each of these plans is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Benefits Hotline at 1-213-388-9982. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov and www.healthcare.gov.

Medical Plans Comparison Chart—Union-Sponsored Plans

	CAPE/BLUE SHIELD LITE POS PLAN			CAPE/BLUE SHIELD CLASSIC POS PLAN			ALADS/ANTHEM BLUE CROSS PRUDENT BUYER BASIC AND PREMIER PLANS*		ALADS/ANTHEM BLUE CROSS CALIFORNIACARE BASIC AND PREMIER PLANS*	FIRE FIGHTERS LOCAL 1014 MEDICAL PLAN
	HMO	IN-NETWORK	OUT-OF-NETWORK	HMO	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK		
Annual Deductible	None	$500/person; $1,000/family		None	$300/person; $600/family		$200/person; $600/family	$200/person; $600/family	None	$200/person; $600/family
Annual Out-Of-Pocket Maximum	$2,000/person; $4,000/family	After deductible, $4,000/person; $8,000/family	After deductible, $6,000/person; $12,000/family	$2,000/person; $4,000/family	After deductible, $4,000/person; $8,000/family	After deductible, $6,000/person; $12,000/family	$450/person (after deductible)	$6,000/person (after deductible)	$500/person; $1,500/family (excludes infertility treatment)	After deductible, In-network: $1,000/person $1,000/family Out-of-network: $1,500/person $1,500/family
		(combined in- and out-of-network)			(combined in- and out-of-network)					
Lifetime Maximum Benefit	Unlimited	Unlimited		Unlimited	Unlimited		Unlimited		Unlimited	Unlimited
PREVENTIVE CARE										PREVENTIVE CARE
Immunizations	100%	100%	100%	100%	100%	100%	90% after deductible (children up to age 7 only)	70% after deductible (children up to age 7 only)	$5 copay	100%, as part of annual $600 "Wellness" benefit
Periodic Health Evaluations	100% (including well baby, well woman exam, Pap smear and mammography)	100% (including well baby, well woman exam, Pap smear and mammography; no deductible)	100% (including well baby, well woman exam, Pap smear and mammography; no deductible)	100% (including well baby, well woman exam, Pap smear and mammography)	100% (including well baby, well woman exam, Pap smear and mammography; no deductible)	100% (including well baby, well woman exam, Pap smear and mammography; no deductible)	Up to age 7: 90% after deductible; age 7 and over: $25 copay/visit ($250 max/calendar year)	Up to age 7: 70% after deductible; age 7 and over: not covered	$5 copay/visit	No deductible; routine exams and screenings (up to $600 combined annual max); well woman, well man, well child benefits also available
Vision Care	100% (up to age 18 for screenings only); one annual eye exam after $10 copay at MES providers only	*MES Provider* One annual eye exam after $10 copay *Non-MES Provider* Ophthalmologist exams: up to $60 reimbursement Optometrist exams: up to $50 reimbursement	*Non-MES Provider* Ophthalmologist exams: up to $60 reimbursement Optometrist exams: up to $50 reimbursement	100% (up to age 18 for screenings only); one annual eye exam after $10 copay at MES providers only	*MES Provider* One annual eye eam after $10 copay *Non-MES Provider* Ophthalmologist exams: up to $60 reimbursement Optometrist exams: up to $50 reimbursement	*Non-MES Provider* Ophthalmologist exams: up to $60 reimbursement Optometrist exams: up to $50 reimbursement	Exams, lenses, frames or contacts covered through VSP; 90% after deductible up to $1,500/eye for radial keratotomy	Exams, lenses, frames or contacts covered through VSP; 70% after deductible up to $1,500/eye for radial keratotomy	Exams, lenses, frames or contacts covered through VSP	Exams, lenses, frames or contacts covered through VSP. See medical plan SPD for details. LASIK benefit 80% after deductible; up to $1,500/eye
MEDICALLY NECESSARY CARE										MEDICALLY NECESSARY CARE
Ambulance	100% after $50 copay	80% after deductible	80% of allowable amount (after deductible)	100% after $50 copay	90% after deductible	90% of allowable amount (after deductible)	80% after deductible	80% after deductible	100%	90% after deductible**
Doctor Office Visit	100% after $10 copay	100% after $25 copay (for consultation only, not subject to deductible)	60% of allowable amount (after deductible)	100% after $10 copay	100% after $20 copay (for consultation only, not subject to deductible)	60% of allowable amount (after deductible)	90% after deductible	70% after deductible	$5 copay/visit	90% after deductible**
Emergency Room	100% after $50 copay (waived if admitted)	100% after $50 copay (waived if admitted)	100% after $50 copay (waived if admitted)	100% after $50 copay (waived if admitted)	100% after $50 copay (waived if admitted)	100% after $50 copay (waived if admitted)	90% after deductible	70% after deductible	No charge if admitted as inpatient; $25 copay/visit if outpatient	$50 copay/visit (waived if admitted)
Hospital Care	100%	80% after deductible	60% of allowable amount (after deductible), up to $360 carrier max/day	100%	90% after deductible	60% of allowable amount (after deductible), up to $360 carrier max/day	90% after deductible (precertification required or coverage reduced by 20%)	70% after deductible (precertification required or coverage reduced by 20%)	100%	90% after deductible; preauthorization required**
Maternity	100%	100% after $25 copay/visit (for consultation only, not subject to deductible)	60% of allowable amount (after deductible)	100%	100% after $20 copay/visit (for consultation only, not subject to deductible)	60% of allowable amount (after deductible)	90% after deductible (precertification required or coverage reduced by 20%)	70% after deductible (precertification required or coverage reduced by 20%)	$5 copay/visit	90% after deductible**
Surgery	100% (outpatient $75 copay)	80% after deductible	60% of allowable amount (after deductible) Outpatient: up to $360 carrier max/day	100% (outpatient $50 copay)	90% after deductible	60% of allowable amount (after deductible) Outpatient: up to $360 carrier max/day	90% after deductible (precertification required or coverage reduced by 20%)	70% after deductible (precertification required or coverage reduced by 20%)	100%	90% after deductible**
X-Ray & Lab Tests	100%	80% after deductible	60% of allowable amount (after deductible)	100%	90% after deductible	60% of allowable amount (after deductible)	90% after deductible	70% after deductible	100%	90% after deductible (other than periodic health exams)**
Prescription Drugs	$5 generic; $15 brand; $30 non-formulary Mail order (90-day supply): $10 generic; $30 brand; $60 non-formulary	$5 generic; $15 brand; $30 non-formulary Mail order (90-day supply): $10 generic; $30 brand; $60 non-formulary	Covered for emergencies only — copay applies	$5 generic; $15 brand; $30 non-formulary Mail order (90-day supply): $10 generic; $30 brand; $60 non-formulary	$5 generic; $15 brand; $30 non-formulary Mail order (90-day supply): $10 generic; $30 brand; $60 non-formulary	Covered for emergencies only — copay applies	$5 copay for generic $10 copay for brand Mail order (90-day supply): $5 copay for generic $5 copay for brand	$5 copay for generic $10 copay for brand (plus 50% of covered expenses)	$5 copay for generic $10 copay for brand Mail order (90-day supply): $5 copay for generic $5 copay for brand	$10 copay for generic; $20 copay for brand (when generic unavailable); $30 copay for brand plus cost above generic allowance (when generic available)
	(non-formulary must be preapproved by Blue Shield)			(non-formulary must be preapproved by Blue Shield)						
MENTAL HEALTH CARE										MENTAL HEALTH CARE
Mental Health Outpatient	100% after $10 copay	100% after $25 copay for consultation only (not subject to deductible)	60% of allowable amount (after deductible)	100% after $10 copay	100% after $20 copay for consultation only (not subject to deductible)	60% of allowable amount (after deductible)	$20 copay/visit (up to 50 combined visits/calendar year) parity diagnosis treated as any other illness	$25 visit paid (up to 50 combined visits/calendar year) parity diagnosis treated as any other illness	$20 copay/visit (up to 50 combined visits/calendar year) parity diagnosis treated as any other illness	90% after deductible**
	Provided by United Behavioral Health. Must be arranged through MHSA			Provided by United Behavioral Health. Must be arranged through MHSA			*Provided by The Holman Group*			
Mental Health Inpatient	100%	80% after deductible	60% of allowable amount (after deductible), up to $360 carrier max/day	100%	90% after deductible	60% of allowable amount (after deductible), up to $360 carrier max/day	20% copay (up to 30 days/calendar year) parity diagnosis treated as any other illness	Covered for emergencies only— 20% copay applies parity diagnosis treated as any other illness	No charge (up to 50 days/calendar year) parity diagnosis treated as any other illness	90% after deductible**
	Provided by United Behavioral Health. Must be arranged through MHSA			Provided by United Behavioral Health. Must be arranged through MHSA			*Provided by The Holman Group*			
OTHER PLAN BENEFITS										OTHER PLAN BENEFITS
Chiropractic Care	100% after $15 copay	100% after $15 copay	Not covered	100% after $10 copay	100% after $10 copay	Not covered	90% after deductible	70% after deductible	$5 copay (up to 20 visits/calendar year)	90% after deductible** (up to 30 total visits/calendar year; combined limit for chiropractic and acupuncture)
	Includes acupuncture; up to 30 combined visits/calender year (based on medical necessity); Provided through American Specialty Health Plans			Includes acupuncture; up to 40 combined visits/calender year (based on medical necessity); Provided through American Specialty Health Plans						
Home Health Care	100% after $10 copay	80% after deductible	60% of allowable amount (after deductible)	100% after $10 copay	90% after deductible	60% of allowable amount (after deductible)	90% after deductible	70% after deductible	$5 copay (up to 4 hrs/day max)	90% after deductible (maximum 100 visits/ calendar year)
	(up to 100 combined visits/calendar year)			(up to 100 combined visits/calendar year)						
Hospice Care	100% when provided by authorized hospice agency			100% when provided by authorized hospice agency			80% after deductible	80% after deductible	100%	90% after deductible ($20,000 lifetime max)
Physical Therapy	100% after $10 copay	80% after deductible	60% of allowable amount (after deductible)	100% after $10 copay	90% after deductible	60% of allowable amount (after deductible)	90% after deductible	70% after deductible	$5 copay (up to 60 days/illness or injury)	90% after deductible (30 visits/calendar year)
Skilled Nursing Facility	100%	80% after deductible	60% of allowable amount (after deductible)	100%	90% after deductible	60% of allowable amount (after deductible)	90% after deductible	70% after deductible	100% (up to 100 days/calendar year)	90% after deductible**
	(up to 100 combined days/calendar year)			(up to 100 combined days/calendar year)						

Indicates Plan Changes

This comparison chart provides a general overview of the Options benefit medical and dental plans. It is provided for your convenience and is not intended to be detailed or comprehensive. Additional details about your benefits are available in other official plan documents, including official summary plan descriptions (SPD). To request a copy of an official plan document, contact the plan's Customer Service department directly.

Should you note any difference between what you read in this comparison chart and an official plan document, the official plan document will rule.

* The ALADS Blue Cross CaliforniaCare and Prudent Buyer Premier Plans offer full dental coverage; the Basic plans do not.

** For out-of-network care, the plan pays 70% after deductible. Refer to the Local 1014 Medical Plan Summary Plan Description (SPD) for a complete description of plan benefits.